

		FOR OHF USE					

LL 1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0022996</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Iona Glos SLC</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>July 1, 2000</u> to <u>June 30, 2001</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>50 S. Fairbanks</u> <u>Addison</u> <u>60101</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>DuPage</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____	
Telephone Number: <u>(630) 620-2222</u> Fax # <u>(630) 628-2350</u>		(Type or Print Name) <u>John Budzynski</u>	
IDPA ID Number: <u>36-2411166-001</u>		(Title) <u>Chief Financial Officer</u>	
Date of Initial License for Current Owners: <u>November 18, 1980</u>		(Signed) _____ (Date) _____	
Type of Ownership:		Paid Preparer (Print Name and Title) _____	
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT		(Firm Name & Address) _____	
<input checked="" type="checkbox"/> Charitable Corp.		(Telephone) <u>()</u> Fax # <u>()</u>	
<input type="checkbox"/> Trust		MAIL TO: OFFICE OF HEALTH FINANCE	
IRS Exemption Code <u>E9982-6984-02</u>		ILLINOIS DEPARTMENT OF PUBLIC AID	
<input type="checkbox"/> PROPRIETARY		201 S. Grand Avenue East	
<input type="checkbox"/> Individual		Springfield, IL 62763-0001	
<input type="checkbox"/> Partnership		Phone # (217) 782-1630	
<input type="checkbox"/> Corporation			
<input type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
GOVERNMENTAL			
<input type="checkbox"/> State			
<input type="checkbox"/> County			
<input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact:			
Name: <u>Kathleen Francis</u> Telephone Number: <u>(630) 620-2222</u>			

Facility Name & ID Number Iona Glos SLC# 0022996 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsno change

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	<u>100</u>	Intermediate/DD	<u>100</u>	<u>36,500</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>100</u>	TOTALS	<u>100</u>	<u>36,500</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>35,764</u>			<u>35,764</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>35,764</u>			<u>35,764</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 97.98%

D. How many bed-hold days during this year were paid by Public Aid?

736 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)none

F. Does the facility maintain a daily midnight census?

yesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 11 / 18 / 80

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 6/30 Fiscal Year: 6/30

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number Iona Glos SLC

0022996

Report Period Beginning: July 1, 2000

Ending: June 30, 2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	137,375		12,110	149,485		149,485		149,485			1
2	Food Purchase		245,279		245,279		245,279		245,279			2
3	Housekeeping		88,089	60,565	148,654		148,654	(10)	148,644			3
4	Laundry											4
5	Heat and Other Utilities			140,934	140,934		140,934	(96)	140,838			5
6	Maintenance	65,482	75,743		141,225		141,225	5,851	147,076			6
7	Other (specify):* waste removal			13,130	13,130		13,130		13,130			7
8	TOTAL General Services	202,857	409,111	226,739	838,707		838,707	5,745	844,452			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	495,323	74,553	59,980	629,856	145	630,001		630,001			10
10a	Therapy	1,533,265		47,388	1,580,653		1,580,653		1,580,653			10a
11	Activities	37,499	24,107		61,606	39	61,645	(21)	61,624			11
12	Social Services	36,801			36,801		36,801		36,801			12
13	Nurse Aide Training	25,777			25,777		25,777		25,777			13
14	Program Transportation	71,932		29,803	101,735	5,434	107,169		107,169			14
15	Other (specify):* lic/ceft & schXVIII	110,982	1,029	34,411	146,422	23	146,445		146,445			15
16	TOTAL Health Care and Programs	2,311,579	99,689	171,582	2,582,850	5,641	2,588,491	(21)	2,588,470			16
	C. General Administration											
17	Administrative	392,260			392,260		392,260	(24,184)	368,076			17
18	Directors Fees											18
19	Professional Services			55,313	55,313	(323)	54,990	(22,471)	32,519			19
20	Dues, Fees, Subscriptions & Promotions			28,840	28,840	41	28,881	(2,924)	25,957			20
21	Clerical & General Office Expenses	305,368	73,832		379,200	11	379,211	(9,010)	370,201			21
22	Employee Benefits & Payroll Taxes			517,204	517,204	(28)	517,176	(5,636)	511,540			22
23	Inservice Training & Education			3,340	3,340	(17)	3,323	(8)	3,315			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			2,426	2,426	76	2,502	(511)	1,991			25
26	Insurance-Prop.Liab.Malpractice			51,975	51,975		51,975	(216)	51,759			26
27	Other (specify):* see worksheet 3			6,703	6,703	(129)	6,574	(1,643)	4,931			27
28	TOTAL General Administration	697,628	73,832	665,801	1,437,261	(369)	1,436,892	(66,603)	1,370,289			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,212,064	582,632	1,064,122	4,858,818	5,272	4,864,090	(60,879)	4,803,211			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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Facility Name & ID Number Iona Glos SLC

#0022996

Report Period Beginning: July 1, 2000 Ending:

June 30, 2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			146,830	146,830		146,830	133,126	279,956			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,840	7,840	(15)	7,825	137	7,962			32
33	Real Estate Taxes			1,057	1,057		1,057		1,057			33
34	Rent-Facility & Grounds			72,386	72,386	(629)	71,757	(5,784)	65,973			34
35	Rent-Equipment & Vehicles			48,089	48,089	(4,628)	43,461	(9,786)	33,675			35
36	Other (specify):*											36
37	TOTAL Ownership			276,202	276,202	(5,272)	270,930	117,693	388,623			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			10,124	10,124		10,124		10,124			41
42	Provider Participation Fee			293,536	293,536		293,536		293,536			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			303,660	303,660		303,660		303,660			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,212,064	582,632	1,643,984	5,438,680		5,438,680	56,814	5,495,494			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

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Facility Name & ID Number Iona Glos SLC

0022996

Report Period Beginning: July 1, 2000

Ending: June 30, 2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	137	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,764)	27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	10,426	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule see page 5A	(67,583)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (62,784)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	119,598		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 119,598		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 56,814		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Iona Glos SLC

ID# 0022996
 Report Period Beginning: July 1, 2000
 Ending: June 30, 2001

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Adjustment for Fund Raising = 50% of Public	\$		1
2	Relations and Development - also see worksheet 1			2
3				3
4	Supplies	(10)	3	4
5	Utilities	(96)	5	5
6	Maintenance	(49)	6	6
7	Activities	(21)	11	7
8	Administrative	(21,351)	17	8
9	Publications	(211)	20	9
10	Membership Dues	(331)	20	10
11	Clerical and General Office	(9,010)	21	11
12	Employee Benefits and Payroll Taxes	(5,636)	22	12
13	Staff Training	(8)	23	13
14	Travel	(334)	25	14
15	Insurance	(216)	26	15
16	Agency Functions	(874)	27	16
17	Depreciation	(682)	30	17
18	Rent	(5,784)	34	18
19	Equipment Rental	(989)	35	19
20	Total Fund Raising Adjustment	(45,602)		20
21				21
22	Other Non-Allowables and Adjustments			22
23	Administrative Other Compensation	(2,833)	17	23
24	Non-Care Related Legal and Professional Services	(22,471)	19	24
25	Non-Care Related Membership Dues	(2,382)	20	25
26	Non-Care Related Administrative Travel	(177)	25	26
27	Non-Care Related Miscellaneous	(81)	27	27
28	In & Out	896	27	28
29	Agency Functions	(6,246)	27	29
30	Depreciation Adjustments	13,450	30	30
31	Non-Care Related Administrative Leased Vehicle	(2,137)	35	31
32	Total Other Non-Allowables and Adjustments	(21,981)		32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(67,583)		49

Summary A

0022996

Report Period Beginning:

July 1, 2000

Ending:

June 30, 2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Facility Name & ID Number Iona Glos SLC

0022996

Report Period Beginning: July 1, 2000 Ending: June 30, 2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Not for Profit Corp - board members DO NOT have ownership in the Ray Graham Association or the Ray Graham Foundation see attached list of board of directors				Ray Graham Foundation	Downers Grove, IL	social service foundation
no board members directly provided service to the SLC						
no board members have ownership in any entity that conducted buseness transactions with the SLC						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6 maintenance	\$	Ray Graham Foundation Downers Grove, IL		\$ 5,900	\$ 5,900	1
2	V							2
3	V	30 building depreciation		Ray Graham Foundation Downers Grove, IL		114,488	114,488	3
4	V							4
5	V	30 equipment depreciation		Ray Graham Foundation Downers Grove, IL		5,870	5,870	5
6	V							6
7	V	35 vehicle lease	6,660	Ray Graham Foundation Downers Grove, IL			(6,660)	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 6,660			\$ 126,258	\$ * 119,598	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

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Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2	none										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Iona Glos SLC # 0022996 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Ray Graham Foundation
 Street Address 2801 Finley Road
 City / State / Zip Code Downers Grove, IL 60532
 Phone Number (630) 620-2222
 Fax Number (630) 628-2350

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	see worksheet 1				\$ 2,399,779	\$ 1,277,727			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 2,399,779	\$ 1,277,727		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	Lucent/AVAYA Financial		X	Phone System - Admin	\$967.00	7/1/97	\$	50,369	\$	11,250	7/1/02	0.0560	\$	723	1				
2	American National Bank		X	Computers - Admin	\$757.00	12/24/98		24,176		4,455	12/30/01	0.0775		712	2				
3	totals				\$1,724.00			\$74,545.00		\$15,705.00				\$1,434.86	3				
4	SLC allocatin = .30				\$517.20			\$22,363.50		\$4,711.50				\$430.46	4				
5															5				
	Working Capital																		
6	allocated - see worksheet 6			operating funds				177,357		177,357				7,531	6				
7	NOTE:COL 4 LINE 9 AMOUNT														7				
8	WRONG DUE TO PROTECTION														8				
9	TOTAL Facility Related				\$3,965.20		\$	199,721	\$	182,069				\$	7,961	9			
	B. Non-Facility Related*																		
10															10				
11															11				
12															12				
13															13				
14	TOTAL Non-Facility Related						\$		\$					\$	14				
15	TOTALS (line 9+line14)						\$	199,721	\$	182,069				\$	7,961	15			

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number **Iona Glos SLC**# **0022996** Report Period Beginning: **July 1, 2000** Ending: **June 30, 2001****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2000 report.		\$ 895	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (895)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 1,952	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 1,057	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1996 972	8	
	1997 305	9	
	1998 310	10	
	1999 886	11	
	2000 1,039	12	
4. 1/2 of 1999 bill = 443 plus 2000 accrual = 967 plus 1/2 of 2001 accrual = 538			
also see worksheet 10			

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

FACILITY NAME	Iona Glos SLC	COUNTY	DuPage
---------------	---------------	--------	--------

FACILITY IDPH LICENSE NUMBER 0022996

CONTACT PERSON REGARDING THIS REPORT Kathleen Francis

TELEPHONE (630) 620-2222 FAX #: (630) 628-1488

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:
 47,000

B. General Construction Type:
 Exterior
 brick
 Frame
 Number of Stories
 1

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☒ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	SLC		1990	\$ 214,674	1
2					2
3	TOTALS			\$ 214,674	3

Facility Name & ID Number Iona Glos SLC

0022996

Report Period Beginning:

July 1, 2000 Ending: June 30, 2001

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	100		1981	1981	\$ 3,681,931	\$ 92,048	40	\$ 92,048		\$ 1,886,990	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Prior Fiscal Years			1995	59,281	5,928	3-5	5,928		59,281	9
10				1996	244,468	41,961	3-5	41,961		226,328	10
11				1997	223,702	44,740	3-5	44,740		200,992	11
12				1998	47,104	9,511	3-5	9,511		28,575	12
13				2000	1,910	191	10	191		286	13
14											14
15	shed			2001	841	140	3	140		140	15
16											16
17											17
18	Fullerton Building allocation										
19	tile work - bathroom			2001	7,997	400	10	400		400	19
20	fuses, holders & installations			2001	1,211	121	5	121		121	20
21	painting - interior			2001	9,500	950	5	950		950	21
22	water meter valve installed			2001	2,285	229	5	229		229	22
23	total Fullerton				20,993	1,699		1,699		1,699	23
24	Transportation portion - .65%				136	11		11		11	24
25	Intake portion - .45%				94	8		8		8	25
26	Clinical portion - .25%				53	4		4		4	26
27	Advocacy portion - .44%				92	7		7		7	27
28	Administration portion - 12.2%				2,561	207		207		207	28
29	SLC portion of Transportation - 6.59%				9	1		1		1	29
30	SLC portion of Intake - 2%				2	0		0		0	30
31	SLC portion of Clinical - 4%				2	0		0		0	31
32	SLC portion of Advocacy - 30.04%				28	2		2		2	32
33	SLC portion of Administration - 30%				770	62		62		62	33
34	total SLC portion				811	66		66		66	34
35											35
36	continue to page 12A										

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	From Ray Graham Association Foundation	1999	\$ 59,303	\$ 7,050	10	\$ 7,050	\$	\$ 17,624	37
38	From Prior Fiscal Years	2000	114,746	11,475	10	11,475		17,083	38
39									39
40									40
41	windows replaced	2001	42,281	2,114	10	2,114		2,114	41
42	home 2 tub room renovation including hydrolic lift tub	2001	13,974	699	10	699		699	42
43	installed, new tile on floor and walls, painting, and new light fixtures								43
44	door replacements and repairs	2001	14,065	703	10	703		703	44
45	carpeting for home 2	2001	4,842	242	10	242		242	45
46	Tempstar air conditioner package	2001	3,150	158	10	158		158	46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,512,410	\$ 217,026		\$ 217,026	\$	\$ 2,441,281	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including

****Improvement type must be detailed in order for the cost report to be considered complete.**

****Improvement type must be detailed in order for the cost report to be considered complete.**

XI. OWNERSHIP COSTS (continued)

1	3	4	5
---	---	---	---

****Improvement type must be detailed in order for the cost report to be considered complete.**

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 113,566	\$ 17,509		\$ 17,509	\$	\$ 80,940	1
2	THIS IS REALLY PAGE 13C - EQUIPMENT DEPRECIATION								2
3									3
4	Management and General -								4
5	Purchased in Prior Years		167,230	33,300	3-5	33,300		109,220	5
6	SLC portion - 30%		50,470	10,050		10,050		32,963	6
7									7
8									8
9	Current Year Purchases								9
10	Generl Motors donation of office furniture including many desks,		29,533	2,953	5	2,953		2,953	10
11	credenzas, filing cabinets, chairs, modual workstations, & particians								11
12	Dell pc (2)		4,404	440	5	440		440	12
13	Dell pc - PIII 866 GX110,133 MHz (7)		3,747	375	5	375		375	13
14	Donor Perfect software, training, & support		6,129	613	5	613		613	14
15	Dell pc		1,088	109	5	109		109	15
16	Quickbooks software		506	51	5	51		51	16
17	Inspiron 4000, PIII, 650Mhz, 8x DVD		1,940	194	5	194		194	17
18	Microsoft donation of software and licenses		199,862	19,986	5	19,986		19,986	18
19	NEC Elite phone system & netwaork cabling		2,608	261	5	261		261	19
20	Dell pc		1,059	106	5	106		106	20
21	current year total		250,877	25,088		25,088		25,088	21
22	SLC allocation - 30%		75,715	7,572		7,572		7,572	22
23									23
24									24
25	Fully Depricatied		25,200					25,200	25
26	SLC allocation - 30%		7,560					7,560	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 247,310	\$ 35,131		\$ 35,131	\$	\$ 129,034	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including

****Improvement type must be detailed in order for the cost report to be considered complete.**

****Improvement type must be detailed in order for the cost report to be considered complete.**

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 180,069	\$ 31,443	\$ 31,443	\$		\$ 136,347	71
72	Current Year Purchases	94,622	9,457	9,457			9,457	72
73	Fully Depreciated Assets	17,024					17,024	73
74	also see pages 12B,12C,12D,12E/13A,13B,13C,13D							74
75	TOTALS	\$ 291,716	\$ 40,900	\$ 40,900	\$		\$ 162,829	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	client transportation	1992 Ford Econoline	1995	\$ 6,654	\$ 222	\$ 222	\$	5	\$ 6,654	76
77	client transportation	1997 Dodge MiniVan	1997	35,401	7,080	7,080		5	31,861	77
78	client transportation	1998 Dodge Van	1998	36,417	7,283	7,283		5	18,209	78
79	client transportation	1999 Dodge Van	1999	37,203	7,441	7,441		5	18,602	79
80	TOTALS			\$ 115,675	\$ 22,026	\$ 22,026	\$		\$ 75,325	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,134,475	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 279,952	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 279,952	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,679,434	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	none	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	none	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Stojka Brothers Partnership and Real Estate Opportunity Corp - see worksheet 7

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		n/a	10/15/98	\$ 7,148	5	n/a	3
4	Additions		n/a	01/27/98	58,826	6	n/a	4
5								5
6								6
7	TOTAL				\$ 65,974			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease n/a.

9. Option to Buy: ☐ YES ☒ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 33,676 Description: see worksheet 8

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning 10/15/98 & 02/26/98

Ending 10/14/03 & 02/25/04

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 06/2002 \$ 58,582

13. 06/2003 \$ 58,803

14. 06/2004 \$ 59,031

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
	IN-HOUSE PROGRAM <u>50</u>	IN-HOUSE PROGRAM <u>80</u>
	IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
	COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE <u>80</u>
	HOURS PER AIDE <u>50</u>	

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$		\$	
2	Books and Supplies		1,225		1,225
3	Classroom Wages (a)		9,914		9,914
4	Clinical Wages (b)		15,863		15,863
5	In-House Trainer Wages (c)		9,065		9,065
6	Transportation				
7	Contractual Payments	information from drop outs not available			
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 36,067	\$	\$ 36,067
10	SUM OF line 9, col. 1 and 2 (e)	\$ 36.067			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ n/a

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	<u>49</u>
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	<u>49</u>

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	none	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)									
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 23,832	\$	1
2	Cash-Patient Deposits	140,046		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 46,963)	1,645,358		3
4	Supply Inventory (priced at cost)	26,428		4
5	Short-Term Investments			5
6	Prepaid Insurance	115,054		6
7	Other Prepaid Expenses	48,478		7
8	Accounts Receivable (owners or related parties)	14,586		8
9	Other(specify): security deposits	33,070		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,046,852	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,641,040		15
16	Equipment, at Historical Cost	2,747,291		16
17	Accumulated Depreciation (book methods)	(3,509,491)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 878,840	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,925,692	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,241,154	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	140,046		28
29	Short-Term Notes Payable	270,179		29
30	Accrued Salaries Payable	1,222,501		30
31	Accrued Taxes Payable (excluding real estate taxes)	30,058		31
32	Accrued Real Estate Taxes(Sch.IX-B)	53,018		32
33	Accrued Interest Payable			33
34	Deferred Compensation	60,880		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	capital lease obligations	11,250		36
37	deferred income	96,083		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,125,169	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	32,731		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Temporarily Restricted	75,148		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 107,879	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,233,048	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (307,356)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,925,692	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4	NOT APPLICABLE		4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(34,780)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (34,780)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (34,780)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,114,246	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,114,246	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	8,335	10
11	Nurses Aide Training Reimbursements	56,294	11
12	Gift and Coffee Shop	11,485	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 76,114	23
	D. Non-Operating Revenue		
24	Contributions	192,866	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 192,866	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	management fees	12,682	28
28a	fundraising	7,992	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 20,674	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,403,900	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	838,707	31
32	Health Care	2,582,850	32
33	General Administration	1,437,261	33
	B. Capital Expense		
34	Ownership	276,202	34
	C. Ancillary Expense		
35	Special Cost Centers	10,124	35
36	Provider Participation Fee	293,536	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,438,680	40
41	Income before Income Taxes (line 30 minus line 40)**	(34,780)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (34,780)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? n/a If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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Facility Name & ID Number Iona Glos SLC

0022996

Report Period Beginning: July 1, 2000

Ending:

June 30, 2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,049	2,097	47,280	22.55	3
4	Licensed Practical Nurses	14,950	15,084	288,862	19.15	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees	3,536	3,536	25,777	7.29	6
7	Licensed Therapist	1,120	1,141	22,992	20.15	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,446	3,306	37,499	11.34	10
11	Social Service Workers	1,347	1,347	36,801	27.32	11
12	Dietician					12
13	Food Service Supervisor	2,034	1,998	29,822	14.93	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,003	11,025	107,553	9.76	15
16	Dishwashers					16
17	Maintenance Workers	4,384	4,429	65,482	14.78	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,952	2,092	61,084	29.20	20
21	Assistant Administrator	1,380	1,380	24,337	17.64	21
22	Other Administrative	9,267	9,375	173,388	18.49	22
23	Office Manager					23
24	Clerical	4,708	4,968	55,286	11.13	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	10,951	10,715	159,182	14.86	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	148,390	148,359	1,510,273	10.18	30
31	Medical Records					31
32	Other Health Care Drivers	6,364	6,374	71,932	11.29	32
33	Other(specify) see worksheet 2	19,812	19,987	494,515	24.74	33
34	TOTAL (lines 1 - 33)	246,693	247,213	\$ 3,212,065 *	\$ 12.99	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	303	\$ 12,110	1	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	85	3,420	10a	40
41	Occupational Therapy Consultant	488	24,048	10a	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	499	19,920	10a	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychiatrist	38	6,606	15	46
47	Physician & Eye Exams	monthly/visit	19,758	15	47
48	temporary clerical	419	8,047	15	48
49	TOTAL (lines 35 - 48)	1,832	\$ 93,909		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	167	\$ 7,829	10	50
51	Licensed Practical Nurses	869	27,427	10	51
52	Nurse Aides	1,188	24,724	10	52
53	TOTAL (lines 50 - 52)	2,224	\$ 59,980		53

Facility Name & ID Number Iona Glos SLC

0022996

Report Period Beginning: July 1, 2000

Ending: June 30, 2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
see worksheet 9			\$ 362,258	Workers' Compensation Insurance	\$ 45,828	IDPH License Fee	\$	
				Unemployment Compensation Insurance	15,224	Advertising: Employee Recruitment	21,263	
				FICA Taxes	229,679	Health Care Worker Background Check	1,030	
				Employee Health Insurance	190,331	(Indicate # of checks performed 200)		
				Employee Meals		publications	997	
				Illinois Municipal Retirement Fund (IMRF)*		memberships	656	
				Pension Plan = 70 employees	15,970	other recruitment expenses:		
				Tuition Reimbursement	8,766	employee referrals	60	
				Employee Incentives	945	TB testing	15	
				Employee Assistance	4,798	pre-employment physicias	1,935	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 362,258	TOTAL (agree to Schedule V, line 22, col.8)	\$ 511,541	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 25,957	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
none			\$	none		\$	Out-of-State Travel	\$
							none	
							In-State Travel	
							Seminar Expense	
							Entertainment Expense	()
							(agree to Sch. V,	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	line 24, col. 8)	\$
C. Professional Services								
Vendor/Payee	Type		Amount					
see worksheet 2			\$ 55,313					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 55,313					

* Attach copy of IMRF notifications

**See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)**

[illegible]

Facility Name & ID Number Iona Glos SLC

STATE OF ILLINOIS

0022996

Report Period Beginning: July 1, 2000

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Ending: June 30, 2000

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? no
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 13,402 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation. _____
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 293,536
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation. _____
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? n/a
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ n/a Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? n/a
d. Have vehicle usage logs been maintained? yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Miller, Cooper & co. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? yes If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? n/a
Attach invoices and a summary of services for all architect and appraisal fees.